Intake Packet

Section 1 of 6: General Information

Today's Date**:** _____

Client Name: _____ D.O.B. _____

Sex: _____ Age/Grade: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Parent/Guardian: _____ *Cell Phone: _____

Home Phone: _____ Work Phone: _____

Relationship to client: _____

*E-mail: _____ Best method of contact: _____

Parent/Guardian: _____ *Cell Phone: _____

Home Phone: _____ Work Phone: _____

Relationship to client: _____

*E-mail: _____ Best method of contact: _____

*Emergency Contact Name: _____

*Emergency Phone Number: _____ *Relationship: _____

Physician Name: _____ Group_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

How did you hear about Westside?

_____From My Doctor
_____Online Search (e.g. Google)
_____Social Media
_____Referred by friends or family

_____Referred by a Westside patient or therapist

_____Other: _____

Allergies and Vaccination History

Please list and describe allergic reactions you have had to food, medications, or insect stings.

Please list food, medication, or insect allergies:	**Describe your reaction:**

Vaccination History: Is your child up-to-date with all vaccinations? (Circle one) **(Yes)** **(No)**

Does your child have an Epi-Pen? (Circle one) **(Yes)** **(No)**

Is your child currently receiving therapy services at another location? (Circle one) **(Yes)** **(No)**

Note: Westside reserves the right to decline services if the child is receiving therapy treatment at another location. If you decide to add services from another provider (other than school service) while being serviced by Westside, you must let us know immediately. We often cannot treat a child with multiple providers.

Primary Insurance

Subscriber Name: _____ Relationship to client: _____

DOB: _____ SS#: _____ Insurance Company: _____

Employer Name: _____

Policy ID #: _____ Group #: _____

Secondary Insurance (if applicable)

Subscriber Name: _____ Relationship to client: _____

DOB: _____ SS#: _____ Insurance Company: _____

Employer Name: _____

Policy ID #: _____ Group #: _____

Section 2 of 6: Release of Medical Information

I,_____, with a date of birth,_____, give my permission for
(Patient name) (Patient's DOB)

Westside Children's Therapy to disclose any of my healthcare information to any of the physicians, healthcare agencies, school's or other child care agency listed below so that he/she can better understand my condition and help me. **I understand that if I do not list an entity, Westside Children's Therapy <u>cannot</u> collaborate and communicate with any other agency to help your child.**
Ex: If you want Westside to be able to work with your child's school, the school has to be listed

Important Party	Relationship	Phone and Fax Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Permission to get sensitive information</u>
By putting my initials by each item below, I understand that I give permission for records to be sent that may contain information about:

_____ Evaluations/Session Notes
_____ Medical History
_____ Diagnosis from Doctor/Script or Referral Information
_____ Parental Concerns Pertaining to Therapy
_____ Appointment Dates/Times
_____ IEP: **If your child has an IEP, Westside requests a copy so that we can align our work**

<u>I understand that:</u>

- I do not have to give my permission to share these records.
- If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.
- This form is only good for 12 months from the date I sign it.

Parent or Legal Guardian Name:_____

Signature: _____Date_____

Section 3 of 6: Consent to ABA, Physical, Occupational, Feeding, Speech Therapy - Evaluation, Treatment

Assumption of Risk, Release, Waiver of Liability and Indemnification

By signing below and accepting services on my behalf and/or on behalf of my family, I, for myself and my family, including my children, acknowledge, agree and hereby voluntarily accept all risk and responsibility associated with the therapy, services and treatment provided by Westside Children's Therapy and its therapists, employees, contracts and agents (collectively "Westside").

I hereby waive all claims, assume all liability, and release and hold harmless, indemnify and agreed to defend Westside from liability for any injury, claim, cause of action, suit, demand and damages (including without limitation, personal, bodily, or mental injury, including death, property damage, economic loss, consequential and indirect damages and punitive damages), whether involving negligence, gross negligence, willful and wanton acts, intentional acts or otherwise, and arising from or related to I or any member of my family's (1) presence at any physical location of Westside and/or (2) receipt of therapy, services and/or treatment from Westside. I further expressly agree that this Assumption of Risk, Waiver of Liability and Indemnification is intended to be as broad and inclusive as permitted by law and that if any portion of it is held invalid, the balance shall be valid and continue in full legal force and effect. These provisions are binding on me, my estate, family, heirs, administrators, personal representatives and assigns.

I am aware and understand that this Assumption of Risk, Waiver of Liability and Indemnification applies to activities and circumstances that are inherently risky and dangerous and involve the risk of serious injury, death and/or property damage. I acknowledge that any injuries I sustain may be compounded by the response of Westside. I acknowledge that I am voluntarily accepting the therapy, services and treatment of Westside with knowledge of the danger involved and hereby agree to assume and accept any and risks of injury, death or property damage, whether caused by Westside or otherwise.

I acknowledge and agree that I understand the provisions contained herein, have had adequate time to review and consider the provisions before signing below and agree that my consent to these provisions is given in exchange for Westside rendering service to me and/or my family and agree that these provisions apply to and at each visit to any Westside location.

Parent or Legal Guardian Name:_____

Signature: _____ Date_____

Section 4 of 6: HIPAA Notice of Privacy Practices

Effective Date: January 1, 2019

This notice is to inform you about how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any question about this notice, please contact David Lapsker, HIPAA Privacy Officer, at (815) 378-1125.

Our Obligations:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How we may disclose information about you:

The following describes the ways that we may use your health information without further authorization
For Treatment: We may use your personal health information to provide you with health care treatment or services. We may share your health information with doctors, nurses, health students, or other personnel who are involved in your care.

For Payment: We may use and disclose your personal health information to help us or another provider obtain payment for the health care services provided. For example, we may give your health plan information about you to obtain prior approval or to determine if your plan will cover the cost of treatment.

For Health Care Operations: We may use your health information to support our business practice activities and improve the quality and cost of care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff. We may use your health information to contact you at the address and phone provided about scheduling, cancelled appointments, insurance updates, billing and/or payment matters.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Military and Veterans: If you are a member of the military or a veteran, we may release your health information to the proper authorities so that they may carry out their duties under the law.

Worker's Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: we may disclose information about you for public health activities. For example, to prevent or control disease or to notify people of recalls of products they may be using.

Individuals Involved in Your Care or Payment of Your Care: If people such as family members, relatives or close personal friends are helping to care for you or helping to pay your medical bills, we may release health information to them. This is limited to the necessary information for your care or for payment for your care.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement: We may release health information if asked to do so by law enforcement officials. For example, we may report certain injuries, as required by law such as gunshot wounds or in response to a court order, subpoena, warrant, summons or similar process.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Protective Services for the President and Others: We may disclose health information about you to authorized officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody or a law enforcement official, we may release health information about you to the correctional institution or law enforcement official.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:
Right to Inspect and Copy: Upon written request you have the right to receive an electronic or paper copy of your medical records and other health information we have about you. Usually this includes health and billing records. If you request a copy of the information we may charge you a fee for the cost of copying, mailing or other supplies and services associated with your request.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to ament the information. To request an amendment your request must be made in writing submitted to the Privacy Officer, and must be legible. In addition, you must provide reason that supports your request for an amendment. We may deny your request if you ask us to ament information that was not created by us, or if the information is accurate and complete.

Right to Accounting of Disclosures: You have the right to an accounting of disclosures of your health information we may have, except for uses and disclosures related to treatment, payment, others with your permission and our health care operations, as previously described. To request this list of disclosures, you must submit the request in writing to our Privacy Officer.

Right to Request Restrictions: Your have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. For example, you could ask that we do not disclose information to your spouse regarding your treatment. Unless the request is to restrict disclosures to your health plan and you agree to pay out of pocket in full for all services provided, we are not required to agree to your request for restrictions unless it is not feasible for us to ensure our compliance or believe it will negatively impact the care we many provide you. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must submit your request in writing to the Privacy Officer.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. To request confidential communications, you must make your request in writing to the Privacy Officer. We will accommodate all reasonable requests.
Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy please request it from the clinic. This notice is also posted on our website at www.westsidect.com

Complaints: You can file a complaint with our HIPAA Privacy Officer or with the U.S. Department of Health and Human Services Office for Civil Rights. If filling a complaint with our office all complaints must be made in writing. If filing a complaint with the U. S. Department of Health and Human Services you can send a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, or call 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints. Filing a complaint will not effect your treatment or the services you receive.

I have read the above summary of Privacy Notice for Westside Children's Therapy, and I agree to the terms listed above.

Parent or Legal Guardian Name:_____

Signature: _____Date_____

Section 5 of 6: Other Policies

Crisis Situations and Physical Management

In the event that a client escalates behaviorally, the therapy team may relocate that individual to a less stimulating environment. If the behavior threatens the safety of the client, therapists or other children, the therapy team may utilize physical management until the situation is de-escalated or no longer deemed necessary. Those engaging in physical management will be properly trained and certified using the Professional Crisis Management (PCM) techniques for transportation, personal safety and/or immobilization.

Consent to Participate in Photo/Video Recording

□ Yes □ No Westside Children's Therapy has my permission to use my or my child's photograph publically to promote Westside Children's Therapy. I understand that the images may be used in print publications, online publications, presentations, websites, and/or social media outlets.

□ Yes □ No Westside Children's Therapy has my permission to use my or my child's photographs or tapes for educational purposes within Westside staff training opportunities, parent training opportunities, and/or obtaining information regarding the functions of behavior.

SMS

Westside Children's Therapy sends occasional SMS communications for reasons **directly** related to my child's therapy. An SMS may include:

- An appointment update
- A key billing update if your balance is increasing
- Key updates during the 'getting started' process
- A cancellation update if you're missing appointments and outcomes are being risked
- Check-ins about how your evaluation process went and how your therapy is going

Intimate Care Policy

Please check as appropriate.

_____ I give my permission to my child's therapist(s) to assist my child in the bathroom should my child need assistance and I am not available.

_____ I give my permission to my child's therapist(s) to change soiled clothing as needed.

By signing below, I acknowledge and agree to the policies outlined above. I have read and understand the Crisis Situation, Consent to Participate in Photo/Video Recording, Consent to SMS and the Intimate Care policies.

Parent or Legal Guardian Name:_____

Signature: _____Date_____

Section 6 of 6: Availability for Sessions

Place an (X) in the box if you are available

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00am - 9:00am					
9:00am - 10:00am					
10:00am - 11:00am					
11:00am - 12:00pm					
12:00pm - 1:00pm					
1:00pm - 2:00pm					
2:00pm - 3:00pm					
3:00pm - 4:00pm					
4:00pm - 5:00pm					
5:00pm - 6:00pm					
6:00pm - 7:00pm *if available					

What therapy services does your child receive? (Circle all that apply).

ABA Feeding Occupational Therapy Physical Therapy Speech Therapy

Top three preferred time slots:

1. _____

2. _____

3. _____